

# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by you or your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>QUEEN ANNE</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GRASONVILLE</b>		c. LENGTH OF STAY IN 1b —		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>QUEEN ANNE</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First		Middle <b>BRINSON JR.</b>		Last		4. DATE OF DEATH Month <b>JAN.</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>UNKNOWN</b>		AGE (In years last birthday) <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OYSTER SHUCKER</b>		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <b>WILLIAM BRINSON</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH WHITE</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT <b>VERDA EATMAN</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial pneumonia</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>old pulmonary tuberculosis and bronchial asthma</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>0022</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) — (State) —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>C. R. Layton</b>		M.D. <b>C. R. Layton</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>C. R. Layton</b>		Address (Street, city, town, or county) <b>Grasonville, Md.</b>		DATE SIGNED <b>Jan. 12, 62</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 15</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Church Hill Colored</b>		22d. LOCATION (City, town, or country) <b>Church Hill Md.</b>		22e. (State) <b>Md.</b>		23. FUNERAL DIRECTOR <b>Edgar L. Lane</b>		ADDRESS <b>Church Hill, Md.</b>	
24a. RECEIVED BY REGISTRAR <b>Jan 18 62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		DATE —		24c. REGISTRAR'S NAME —		24d. REGISTRAR'S ADDRESS —	

THE STATE  
HEALTH DEPT.

01112

CHAS. B. BAKER

1850 VILLAGE

W. L. AM

WIFE

CHAS. B. BAKER

WIFE

VERON, CHAS. B. BAKER

CHAS. B. BAKER

1

01119

## CERTIFICATE OF DEATH

Reg. Dist. No.

01110

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Anthony</u> Last <u>Butler</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>20</u> Year <u>1862</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1890</u>		9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Anthony</u>				14. MOTHER'S MAIDEN NAME <u>Emma Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>218-03-0390</u>		17. INFORMANT <u>Mary Griffin</u> Address <u>Queenstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>422</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u> years <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>12 Hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>7/20</u> , 19 <u>59</u> , to <u>1/20</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>1/20</u> , 19 <u>62</u> , and that death occurred at <u>6:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 S. Liberty St.</u> DATE SIGNED <u>Jan. 22, 1962</u>							
ACTUAL SIGNATURE <u>C. Rodney Layton</u>				M.D. <u>  </u>			
PHYSICIAN'S NAME (Type) <u>C. Rodney Layton</u>				M.D. <u>  </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/25/1962</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hubert H. Holladay</u>				ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 30 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clifford S. House</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## 1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND01120  
CERTIFICATE OF DEATH

01111

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>N. J.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Crumpton</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Pleasantville</b> <b>67X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Davis Nursing Home</b>		d. STREET ADDRESS <b>67X-3</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Samuel</b> Middle <b>W.</b> Last <b>Curlott</b>		<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>25</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 30, 1878</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>3</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Glass Blower</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Glass Factory</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Curlott</b>	
14. MOTHER'S MAIDEN NAME <b>Clara Hall</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Subsistence</b>	
16. SOCIAL SECURITY NO. <b>157-10-2786</b>		17. INFORMANT <b>Earl Price,</b> Address <b>Barelay, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Disturbance</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Chronic myocarditis</b> (a), stating the underlying cause last. } DUE TO <b>Chronic Bronchitis</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sincerely</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>2nd</b>	
20c. TIME OF INJURY Hour a.m. <b>19:20</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>2nd</b>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1961</b> to <b>Jan 25, 1962</b> ; that (I) (we) last saw the deceased alive on <b>Jan 22, 1962</b> and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Edwards</b>		22b. DATE SIGNED <b>4/26/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwards</b>		22d. ADDRESS <b>Sudlersville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 28, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Sudlersville, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows, Millington, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 29 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

(M)

01120

01120

01120

01120

July 20, 1975

Class Secretary

July 21

July 22, 1975

July 23, 1975

Class Secretary

July 24, 1975

July 25, 1975

July 26, 1975

July 27, 1975

July 28, 1975

July 29, 1975

July 30, 1975

August 1, 1975



01121

## CERTIFICATE OF DEATH

Reg. Dist. No. 01112

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crumpton</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>R.</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1962</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13-1895</u>	9. AGE (In years last birthday) yrs. <u>67</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William James Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Seney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT <u>Mrs. Charles Walls--Crumpton</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial sclerosis</u> (c) <u>Chronic myocarditis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary sclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>FD</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>20</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Sudlersville, Md.</u>		(County) (State)	
21. I certify that I attended the deceased from <u>Dec 21, 1961</u> to <u>Jan 19, 1962</u> that I last saw the deceased alive on <u>Jan 17, 1962</u> , and that death occurred at <u>530 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C.H. Metcalfe</u>		M.D. <u>@ 1545 E. City</u>		ADDRESS (Street, city or town, state) <u>Sudlersville, Md.</u>		DATE SIGNED <u>1/21/62</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 21</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 25 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraw...</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

7-11-1918

1-1-18

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
BOSTON, MASS.  
I hereby certify that on the 11th day of July, 1918, at the City of Boston, in the County of Suffolk, Massachusetts, died \_\_\_\_\_  
aged \_\_\_\_\_ years, \_\_\_\_\_  
cause of death \_\_\_\_\_  
attested by \_\_\_\_\_  
Physician  
attested by \_\_\_\_\_  
Registrar of Vital Records  
attested by \_\_\_\_\_  
City Clerk



MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

01122

01113

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Queen Ann</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sudlersville</u> <span style="float: right;">3 Months</span> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Maryland</u> d. STREET ADDRESS <u>None</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>L.</u> Last <u>Faulkner</u>				<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>30</u> Year <u>1962</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1-1-1884</u>			
<b>9. AGE</b> (In years last birthday) <u>78</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>			
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>William Faulkner</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Ware</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>			
<b>17. INFORMANT</b> <u>Robert McGinnis Sudlersville, Md.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> (b) <u>Chronic Hypertension</u> (c) <u>Coronary Artery Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoked</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u>11:30P</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>			
<b>20f. (City or town)</b> <u>Sudlersville</u>		<b>20g. (County)</b> <u>Caroline</u>		<b>20h. (State)</b> <u>Md.</u>			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>Jan 30, 1962</u> to <u>Jan 30, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 30, 1962</u> and that death occurred at <u>11:30P</u> from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>[Signature]</u>				<b>22b. DATE SIGNED</b> <u>2/2/62</u>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>[Signature]</u>				<b>22d. ADDRESS</b> <u>Sudlersville, Md.</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2-3-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Templeville</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Templeville, Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>J. E. Boulois Greensboro, Md.</u>					
<b>25a. REC'D BY REGISTRAR</b> <u>Feb 5 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 15M 9/60

5210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
011123  
011114

Item 9 Film G305 1/26/62 ink

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Centreville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RURAL Centreville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Addie</u> First <u>Hawkins</u> Middle <u>L</u> Last		4. DATE OF DEATH Month <u>Jan</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1891</u> Dec <u>17</u> , 18 <u>91</u>
9. AGE (in years) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LAYMAR GROCE</u>		14. MOTHER'S MAIDEN NAME <u>MARY F. SPARKS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Louis Hawkins</u>		Address <u>Centreville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Coma</u> DUE TO <u>Uncontrolled Diabetes</u> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1962</u> to <u>Jan 16, 1962</u> ; that (I) (we) last saw the deceased alive on <u>Jan 15, 1962</u> , and that death occurred at <u>2:30</u> p.m. from the causes and on the date stated above.			
22a. SIGNATURE <u>C. R. Layton</u>		22b. DATE SIGNED <u>1-19-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>		22d. ADDRESS <u>Centreville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1-20-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Centreville Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Schell</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 24 '62</u>	
ADDRESS <u>EASTON, MD.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

0118

CERTIFICATE OF DEATH

0118

First Certificate of Death  
MAY 1911

Address  
Franklin, N.Y.  
Dec 1911  
W. J. F. Sparks  
Lewis Perkins - General Mgr.

General Manager - Franklin, N.Y.

Reg. Dist. No. 01115

VS AJS (4)  
1SM 9/SB

CERTIFICATE OF DEATH

1912

Blank certificate form with faint lines and text for recording death information.

1-22-12  
1-22-12



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon portions. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01125

CERTIFICATE OF DEATH

Reg. Dist. No. 01116

1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Church Hill</b> c. LENGTH OF STAY IN 1b <b>1</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Near Church Hill</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>O.</b> Last <b>Kirby</b>		4. DATE OF DEATH Month <b>January</b> Day <b>19</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1-1888</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>4</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas B. Chance</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Dill</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Mrs. Jennie Cole--Church Hill, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO <b>Atherosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>years</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>30 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>9-9</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-18</b> , 19 <b>62</b> , to <b>1-18</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>1-18</b> , 19 <b>62</b> , and that death occurred at <b>7:45 A.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>104 S. Liberty St. Centreville, Maryland</b>	
ACTUAL SIGNATURE <b>C.R. Layton</b>		DATE SIGNED <b>1/22/62</b>	
PHYSICIAN'S NAME (Type) <b>C.R. Layton</b>			
22a. BURIAL, CREMATION, REBURYAL, ETC. <b>Burial</b>		22b. DATE THEREOF <b>Jan. 22</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Church Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Church Hill, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar L. Lane</b>		ADDRESS <b>Church Hill, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JAN 24 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

DECLARATION OF DEATH

01152

01152

DECLARATION OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01126 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01117											
1. PLACE OF DEATH a. COUNTY <b>Queen Anne</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Price</b>						c. LENGTH OF STAY IN 1b <b>Price</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS <b>Price</b>					
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Vernon</b> Last <b>Richardson</b>						4. DATE OF DEATH Month <b>Jan.</b> Day <b>16</b> Year <b>1962</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 19-1905</b>		9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>56</b> Days <b>16</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Richardson</b>						14. MOTHER'S MAIDEN NAME <b>Clara Sheubrooks</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>179-07-0494</b>		17. INFORMANT Address <b>Anthony Richardson--Price, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis Probable</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. <b>Body Found 10-14 day Post Death</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Known Heavy Drinker</b>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Feb 3, 1962</b>											
ACTUAL SIGNATURE <b>C. R. Layton</b>				M.D. <b>C. R. Layton</b>				DATE SIGNED <b>Feb 3, 1962</b>			
EXAMINER'S NAME (Type) <b>C. R. Layton</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Feb. 4</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville</b>		22d. LOCATION (City, town, or country) (State) <b>Sudlersville, Md.</b>			
23. FUNERAL DIRECTOR <b>Edgar H. Kane</b>						ADDRESS <b>Church Hill, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 6 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Travis</b>	

TO E

**ATTENDING PHYSICIAN:** The law requires that the death be retained by the hospital or

in 24 hours after

the funeral



(M)

(I)

1111

Green House  
Cattle

30 yds

Woodland  
Cattle

100 Cattle

Woodland

100 Cattle

100 Cattle

Woodland

100 Cattle

100 Cattle

100 Cattle

100 Cattle